

- NEW ENROLLMENT
- CHANGE
- CONVERSION TO NON-GROUP



# ENROLLMENT APPLICATION

P.O. BOX 928  
 TOLEDO, OHIO 43697-0928  
 (866) 380-8900

• PLEASE PRINT OR TYPE • PLEASE DO NOT WRITE IN SHADED AREAS • USE BALL POINT PEN AND PRESS HARD • MAKE SURE APPLICATION IS SIGNED AND DATED

SUBSCRIBER	PREVIOUS MEMBERSHIP WITH PARAMOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ID # _____										
	<input type="checkbox"/> CHANGE NAME PREVIOUS NAME _____					<input type="checkbox"/> CHANGE SUBSCRIBER ADDRESS/PHONE _____					
	SOCIAL SECURITY NUMBER			LAST NAME			FIRST		MIDDLE		
	SUBSCRIBER STREET ADDRESS (IF P.O. BOX, MUST INCLUDE PHYSICAL ADDRESS OF RESIDENCE)						CITY		STATE	CO.	ZIP CODE
	HOME TELEPHONE			WORK TELEPHONE			DATE OF HIRE		* NOTE, IF CHANGING TO FULL-TIME EMPLOYEE STATUS OR IF RECALLED FROM LAYOFF, SPECIFY NEW DATE		
	BIRTH DATE		SEX <input type="checkbox"/> M <input type="checkbox"/> F								
	GROUP NUMBER			DIVISION		EFFECTIVE DATE		CONTRACT TYPE		CODE	CLERK DATE

DEPENDENTS	<input type="checkbox"/> ADD DEPENDENT IF ADDING SPOUSE, MARRIAGE DATE _____									
	LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NO.	BIRTH DATE	SEX	RELATIONSHIP	STATUS	CLASS CODE	OTHER COV.
	DEPENDENT				- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER	FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> HANDICAPPED		
	DEPENDENT				- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER	FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> HANDICAPPED		
	DEPENDENT				- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER	FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> HANDICAPPED		
	DEPENDENT				- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER	FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> HANDICAPPED		
	DEPENDENT				- -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> OTHER	FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> HANDICAPPED		
COMPLETE IF ENROLLING DEPENDENT STUDENT OVER AGE 19			DEPENDENT FIRST NAME/SCHOOL ATTENDING				DEPENDENT FIRST NAME/SCHOOL ATTENDING			

OTHER INSURANCE	ARE YOU OR ANY DEPENDENTS LISTED COVERED BY ANY OTHER HEALTH INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO									
	ARE YOU OR ANY DEPENDENTS COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO									
									IF YES, COMPLETE THIS SECTION.	
	POLICY HOLDER NAME			BIRTHDATE OF POLICY HOLDER		EFFECTIVE DATE		END DATE		TYPE OF COVERAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY
INSURANCE CO.			POLICY NUMBER		FAMILY MEMBERS COVERED					
CHECK ALL THAT APPLY: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DRUG <input type="checkbox"/> VISION <input type="checkbox"/> DENTAL										

AGREEMENT	<p>AGREEMENT: ON BEHALF OF MYSELF AND MY LISTED DEPENDENTS, I UNDERSTAND THAT MY ENROLLMENT AND BENEFITS ARE IN ACCORDANCE WITH THOSE DESCRIBED IN MY PARAMOUNT GROUP CERTIFICATE OF INSURANCE/COVERAGE. I UNDERSTAND THAT I CAN OBTAIN A COPY OF THIS AGREEMENT FROM PARAMOUNT OR MY EMPLOYER. PARAMOUNT IS A COVERED ENTITY UNDER HIPAA AND IS PERMITTED TO USE, OBTAIN AND DISCLOSE MEMBER PROTECTED HEALTH INSURANCE (PHI) TO PERFORM PARAMOUNT OPERATIONS IN ACCORDANCE WITH PARAMOUNT'S NOTICE OF PRIVACY PRACTICES. I SHALL COOPERATE AND ASSIST PARAMOUNT IN THE EXERCISE OF ITS SUBROGATION AND COORDINATION OF BENEFITS RIGHTS INCLUDING AS AGAINST MY OWN OTHER PAYERS AS SET FORTH IN MY EMPLOYER'S CONTRACT WITH PARAMOUNT. I AGREE TO SUBMIT ANY DISPUTES WITH PARAMOUNT THROUGH THE GRIEVANCE PROCEDURE SET FORTH IN MY EMPLOYER'S CONTRACT WITH PARAMOUNT. IF APPROPRIATE, I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY WAGES THE AMOUNT REQUIRED (IF ANY) TO COVER MY CONTRIBUTION FOR COVERAGE. ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST PARAMOUNT, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD UNDER OHIO LAW. IF, AFTER SIGNING THIS APPLICATION, YOU DECIDE TO CANCEL THIS AGREEMENT, YOU MAY DO SO BY SENDING A CERTIFIED LETTER WITHIN SEVENTY-TWO (72) HOURS TO PARAMOUNT AT THE ABOVE ADDRESS. I CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT.</p>										
	INSURED SIGNATURE <b>X</b> _____							DATE _____			
	SPOUSE SIGNATURE <b>X</b> _____							DATE _____			

EMPLOYER	CHECK ONE		GROUP CONTINUATION		COVERAGE WILL BE EFFEC- TIVE IN ACCORDANCE WITH THE ENROLLMENT ELIGIBILI- TY POLICY ESTABLISHED BETWEEN THE GROUP AND PARAMOUNT.
	<input type="checkbox"/> NEW GROUP	<input type="checkbox"/> RECALLED FROM LAYOFF	QUALIFYING EVENT _____		
	<input type="checkbox"/> NEW EMPLOYEE	<input type="checkbox"/> HRA QUALIFIED PLAN	<input type="checkbox"/> STATE OF OHIO - 6 MONTHS		
	<input type="checkbox"/> OPEN ENROLLMENT	<input type="checkbox"/> HSA QUALIFIED PLAN	<input type="checkbox"/> COBRA		
<input type="checkbox"/> PART-TIME TO FULL-TIME		<input type="checkbox"/> 18 MOS. <input type="checkbox"/> 29 MOS. <input type="checkbox"/> 36 MOS.			
COMPANY NAME <b>X</b> _____		EFFECTIVE _____			
EMPLOYER SIGNATURE <b>X</b> _____		EFFECTIVE DATE _____			